TITLE II OF THE AMERICANS WITH DISABILITIES ACT
COMPLAINT FORM

Michigan Department of Human Services

Instructions: Please fill out this form completely, in black ink or type. Sign and return to the address on page 3.

Complainant:

Address:

City, State and Zip Code:

Telephone: Home:

Business:

Person Making the Complaint:
(if other than the complainant)

Address:

City, State and Zip Code:

Telephone: Home:

Business:

County/Program which you believe has discriminated against you:

Name:

Address:

County:

City:

State and Zip Code:

Telephone Number:

When did the event occur? Date:

Describe the event providing the name(s) where possible for the individuals who were involved (use space on page 3 if necessary):

Has the complaint been filed with the Michigan Department of Civil Rights or the Federal Department of Justice or any other federal agency or court?

Yes _____ No _____

If yes:

Agency or Court:

Contact Person:

Address:

City, State and Zip Code:

Telephone Number:

Date Filed:

Do you intend to file with another agency or court?

Yes _____ No _____

Agency or Court:

Address:

City, State and Zip Code:

Telephone Number:

Additional space for answers:

Signature: _____

Date: _____

Return to:

Mary Hall-Thiam
Office of Equal Opportunity and Diversity Programs
PO Box 30037
Lansing, MI 48909
Phone: (517) 373-8520
Fax: (517) 335-6453

Authority:	Sec.709©, title VII, Civil Rights Act of 1969, as amended.	Department of Human Services (DHS) will not discriminate against any individual or group because of race, religion, age, national origin, color, height, weight, marital status, sex, sexual orientation, gender identity or expression, political beliefs or disability. If you need help with reading, writing, hearing, etc., under the Americans with Disabilities Act, you are invited to make your needs known to a DHS office in your area.
Response:	Voluntary	
Penalty:	None	